Macomb County Community Mental Health
Level of Care Training Manual

Introduction

Services to Medicaid recipients are based on medical necessity for the service and not specific diagnoses. Services may be provided to persons who do not meet the target population but who are determined by Macomb County Community Mental Health MCCMH to be at great risk if they are not retained in services. MCCMH Access Division will complete a UM override to allow these persons to continue to be treated

Criteria contained in this manual provide guidelines for the provision of appropriate, cost-effective services that promote recovery from the symptoms of mental illnesses, serious emotional disturbances for children and adolescents and addictive disorders, and lead to recovery or stabilization at the highest level of functioning. They also require consideration of other critical issues, such as a consumer's psychosocial needs; desired outcomes; accessing community resources; and coordination of care between behavioral health, physical health, specialty providers, and other systems of care.

The approach to the delivery of services is based on the premise that individuals are more likely to access appropriate services and remain engaged in treatment when they feel that their needs are understood and met. Through the application of these criteria, staff and clinical providers will be able to provide consumers with comprehensive and individualized services. These include:

1. Assessment and referral to clinical practitioners and programs
2. Assistance with identifying resources to meet basic necessities (e.g., food, housing, transportation, and child care);
3. Working with local human service agencies and educational institutions (e.g., social services, child protective 0services, and school-based programs) to coordinate a continuum of services;
4. Identify Natural supports
5. Identifying community support resources (e.g., peer support, vocational rehabilitation)
6. Providing consumers and family members with educational materials concerning MH disorders; and/or
7. Directing family members to local support groups.

Individuals Served by the MCCMH

The MCCMH program serves members of diverse populations, ranging from individuals who use services to address treatment episodes and those who have longer-term disabilities and are at high risk for recurrence of their mental illness, serious emotional disturbance for children and adolescent disorders, substance use disorders and developmental disabilities. Individuals served by the MCCMH program include, but are not limited to:

- Pregnant women with mental health needs
- Children with Severe Emotional Disturbances and/or substance use disorders

- Adults with severe and persistent mental illness or addictive disorders
- Elderly adults with mental illness (OBRA Assessments)
- Children in out-of-home placement and their families
- Children and families in need of family preservation services
- Persons with Co-occuring condition of mental health and substance use disorder
- Children/adolescents with serious emotional disturbances

Members of each population often present unique challenges for maintaining long-term stability, rehabilitation, and recovery. The treatment approach for all service phases must be tailored to fit a consumer's unique needs, recognizing the complexity of care/service management and the necessity for coordination of clinicians providing primary and specialty medical care.

Level of Care Criteria Manual Development

This manual is based on the guidelines set forth ward in the contract with MDCH, Medicaid Manual, and best practices developed for mental health and clinical services and are specifically applicable to individuals with complex needs.

The mental health statutes and standard clinical references will be modified as necessary. This will occur within the structure of the MCCMH Utilization Management (UM) Committee will consider new or emended criteria based on the experience of staff, providers' requests, as new modalities or programs are identified, as a result of new directions from the state of Michigan or based on findings published by clinical organizations or academic institutions.

Proposed revisions to the criteria will be presented to MCCMH UM Committee. The committee will analyze and respond to the proposed revision/changes and submit it for approval by the Quality Council. Once approved by Quality Council, it will be incorporated into the Level of Care Criteria Manual and distributed to providers for training and implementation. Over and above the ad hoc reviews and subsequent modifications, a comprehensive review of the manual will be conducted at least annually, led by the UM Committee, after annual review the UM Committee will submit request for approval to the Quality Council.

MCCMH protocols for services address all levels of behavioral health care and are designed to facilitate continuity of care through the implementation of an integration of health services model throughout the course of service delivery. The descriptions of services provided under the MCCMH program will be revised as necessary to reflect changes occurring in the national standards for care and as are occurring in the requirements and statutes of the State of Michigan.

MCCMH establishes a collaborative multidisciplinary approach to consumers' care, which relies on a standardized assessment of symptoms and outcomes. Treatment interventions follow evidence-based clinical guidelines. Consumers and family education is emphasized. The goals are:

- Prevent or reduce acute episodes
- Decrease residual symptoms of illness
- Improve overall health

- Increase productivity (improve role functioning), and
- Reduce health care costs.

To accomplish these goals, each of the following components is needed:

- Population health management is a population-specific intervention. A correct diagnosis is critical to achieve optimal outcomes. This is accomplished using standardized assessment tools that are considered valid, reliable, and quantifiable.
- Consumer-Centered Care
- Population Health Management involves a holistic approach to consumer care that focuses on the individual's overall health and ability to function in his or her environment. Treatment planning and identified goals go beyond the narrow consideration of diagnosis and take into account the individual's level of acuity, chronicity, functional status, and psychosocial needs.
- Tailoring care to the consumer's individual needs improves functioning and quality of life outcomes and more efficiently utilize resources.

The following information details the steps that must be taken in order to:

- Assess to determine medical necessity
- Determine appropriate level of care or service
- Refer consumers to appropriate level of care
- Evaluate medical necessity for continued treatment; and
- Plan for discharge and/or transition to a less intensive level of care or home setting, including linkages to community-based services.

These steps are followed to meet the needs of the individual and to keep them in the least restrictive setting, in the community and at the highest level of function.

This approach promotes greater flexibility in service provision, more opportunities for improved skill development and role performance and ultimately better outcome in rehabilitation and recovery. An example is that of the individual who is in an outpatient program and experiences a recurrence of symptoms. This person will not necessarily move to a higher level of care but may have additional services added to the existing service in order to maintain continuity and consistency in the community, acute hospitalization may be required for symptom stabilization, however, in-patient admission does not necessitate a change in level of care

Assessment and Referral

Clinical assessments result in both the assignment of a risk rating and an evaluation of clinical and psychosocial (e.g., family dynamics, support system, financial and social need, homelessness, abuse/neglect, and unemployment) conditions which may significantly alter the impact of the illness on the consumer and his/her environment.

Although psychiatric emergencies are caller defined, Access Managers also assess each call to determine if an emergency exists, even if not defined as such by the caller. Based on the assessment, Access Managers assign a risk rating to the request. When the call is from a provider, Access Managers conduct a telephone review to determine the appropriateness of the proposed level of care and treatment plan. Access Managers facilitate a clinical discussion around symptoms, diagnosis, history, treatment goals, medication, physical health status, and any psychosocial considerations.

Determining Medical Necessity

Access Managers must verify that the proposed services are clinically necessary according to the following four parameters:

- Service must be an adequate and essential response for the evaluation, treatment, or intervention of a mental disorder and psychosocial condition.
- To be considered medically necessary, treatment must address a MH disorder as defined by standard diagnostic nomenclatures (DSM-V, or its equivalent in ICD-9). Psychosocial rehabilitation interventions such as CLS are considered appropriate if they are in response to treatment for a given clinical condition and are expected to maintain and/or improve an individual's functioning level, independence, and quality of life.
- Service must be expected to improve and/or maintain an individual's condition or level of functioning.
- To be considered necessary, interventions must be active and have a reasonable clinical and/or social expectation that they will improve, or are required to maintain, an individual's current condition or psychosocial functioning. Service must meet state and national standards for mental health professional practice.

MCCMH Level of Care Criteria

For services to be considered medically necessary, they must be rendered by licensed and qualified mental health professionals or other providers (such as those employed by an accredited agency or facility as required by contract) who are credentialed by MCCMH.

Such providers include, but are not limited to:

- Board-certified psychiatrists
- Michigan Licensed psychologists
- Michigan Limited License Psychologist
- Licensed Professional Counselors
  Licensed Social Workers
- Licensed chemical dependency counselors; and
- Other Qualified Credential staff/providers (i.e. QMRP, QMHP, CMHP)

Treatment facilities and settings such as the following must be appropriately licensed and accredited to provide the qualified level of care, those are:

- Inpatient programs
- Partial hospitalization
- Residential treatment centers
- Crisis residential services
- Crisis stabilization services
- Community support services
- Supports coordination
- Case Management Services
- Outpatient programs
- Other specific programs as identified for MCCMH

Service must be provided at the most appropriate level of care. Treatment at the appropriate level of care is that which is provided to meet a specific clinical, rehabilitation/recovery, and psychosocial need.

Determining Appropriate Level of Care

Three parameters are used to determine the appropriate level of care:

1. Severity of condition / Criteria for admission
2. Intensity of service criteria
3. Psychosocial factors.

These parameters enable Access Managers to make recommendations based on an understanding of the consumer's individual clinical, physical and psychosocial needs. Diagnosis alone does not determine the necessity of treatment at a given level.

Individuals with the same diagnosis or a single individual may experienced a wide range (severity and frequency) signs and symptoms of mental illness or psychosocial needs. The applicability of these criteria to each individual will depend on the information obtained by the Care/Care/Access Managers from the consumer, behavioral health and medical providers, family members, community personnel and other caregivers.

1. **Severity of Condition / Criteria for Admission**

   <u>These criteria address the question: "What specific clinical condition exists including signs and symptoms that support the presence of a DSM-V diagnosis?"</u>

   These represent, for a given level of care, the signs, symptoms, and functional impairments of such a nature and severity as to require treatment at a specified level at a given point in time.

In addition, the presence of certain "high risk" clinical factors warrants consideration in evaluating a consumer to determine his/her severity of condition. These factors include the following but are not limited to these items:

- Repeated attempts at self-harm, with documented suicidal intent
- Significant Co-Occurring factors (e.g., psychiatric/medical; psychiatric/substance abuse
- psychiatric/mental retardation/development disability; substance abuse/medical)
- Medication non-adherence
- History of violent or assaultive behavior
- Multiple family members requiring treatment

2. **Intensity of Service (IS) Criteria**

These criteria should match the individual's condition, taking into consideration his/her developmental strengths and limitations (e.g., physical, psychological, social, cognitive/intellectual, academic) and psychosocial considerations. The criteria represent therapeutic modalities that, by virtue of their complexity and/or attendant risks, require a specified level of care for their safe, appropriate, and effective application. These criteria address the question:

"Does the individual's condition and situation (e.g., behavior, symptoms, psychosocial issues) warrant this level of care (i.e., is it clinically necessary?)"

For example, acute mental health inpatient services may be necessary for individuals with a condition that results in the expression of suicidal/homicidal ideas, threats, plans, or attempts. While some individuals' condition may be less serious, as defined by Risk Rating Scale, the presence of psychosocial factors (e.g., isolation, chronic illness) may warrant a more intensive level of care.

3. **Psychosocial Considerations**

These represent factors that are aggravating a consumer's clinical condition such that a more intensive level of care may become necessary if the issues are not addressed. These considerations address the question:

"What specific psychosocial factors are present that may change the risk assessment and should be considered when making level of care placement decisions?"

Psychosocial factors to consider in making this determination include:

- Homelessness
- Housing issues (e.g., risk of losing housing; inadequate housing; dissatisfaction with housing arrangements, hazardous living situation, placed at risk for abuse by current housing situation)

- Lack of effective social support (e.g., minimal social network; strained interpersonal relationships, abuse/neglect in living environment, family member with mental illness, single parent or non-parent family)
- Family dynamics
- Physical disability
- Financial difficulties
- Lack of access to medical/dental care
- Recent critical life event (e.g., sudden death of parent or child; divorce)
- Chronic illness
- Isolated (e.g., rural resident, homebound)
- Active legal issues and recent incarceration

Evaluating Clinical Necessity for Continued Care

In evaluating clinical necessity for continued care, three situations may exist:

1. The severity of illness and intensity of service criteria and psychosocial considerations present at the start of treatment continue to apply and no other level of care would be adequate. Access Managers and providers will cite the criteria and any psychosocial issues that apply, and describe the consumer's current functioning to support the decision.

2. New symptoms have emerged so that additional SI/IS criteria and/or psychosocial considerations are applicable to determine adequate level of care suited to current condition. Access Managers and Providers will cite the newly relevant SI/IS criteria and any psychosocial issues, as well as describe the consumer's current functioning to support the decision.

3. Symptom acuity and risk have significantly decreased and psychosocial issues have been addressed to such a degree that a shift to another level of care or addition of other services appears imminent. A brief period of time for continued observation and completion of transition is warranted. Access Managers and providers will cite the level of care followed by the notation, XXXX Transition" and will document justification for transition (e.g., progress in meeting goals).

When evaluating the need for continued care, the Care Manager or Access Manager confirms that the treatment plan:

Remains clinically appropriate and reflects any psychosocial factors which impacted the level of care determination.

The following criteria should be present for continuation of a treatment plan:

1. Progress in relation to specific symptoms or impairments is clearly evident and measurable or stability at the maximum level of function has been obtained and can be sustained only by this level of care

2. Active evaluation and treatment appropriate for the condition are occurring with cooperation of the consumer and his/her family or other support system with timely relief of symptoms either evident or reasonably expected
3. Treatment or rehabilitation goals are realistic and established within an appropriate time frame as well as, frequency of interventions for this level of treatment
4. Psychosocial issues are being addressed through timely referral to and coordination with community and psychosocial rehabilitation resources (e.g., social services agencies, homeless shelters, peer support, recovery groups, legal aid, clubhouse programs, assertive community treatment, warm lines)
5. All service and treatment modalities are carefully structured to achieve maximum results with the greatest efficiency in the use of resources so that the individual is treated at the lowest level of care appropriate to the conditions and achieves the results desired (e.g., a less intensive level of care, reunification of the family).

Discharge Criteria

The discharge criteria reflect the circumstances under which a consumer is able to transition to a less intensive level of care. In the majority of cases, this will entail meeting the appropriate treatment goals as identified in the treatment plan. For some individuals whose condition has not stabilized but has intensified (e.g., exhibits severe behavior such as a suicide/homicide attempt), discharge will involve transition to a more intensive level of care. For children/adolescents in out-of-home placements, discharge may be prompted by reunification with parent(s), transition to a more permanent level of care (e.g., adoption) or an independent living situation, or by symptoms (e.g., psychosis) that require a more highly structured setting. In all discharges from a given level of care, there should be adequate planning for follow-up care that is documented in the record.

In all instances, the discharge criteria should include appropriate follow-up care to assist the individual in maintaining or improving their level of function, support further skill development and role performance.